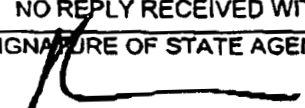
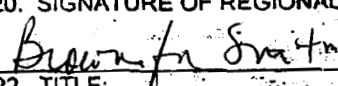


DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATIONFORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: 03 - 24	2. STATE: TEXAS
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE: October 11, 2003	
5. TYPE OF PLAN MATERIAL (Circle One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447.272 42 CFR 447.321		7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT a. FFY 04 \$ 8,743,960 b. FFY 05 \$ 9,972,960	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: SEE ATTACHMENT		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): SEE ATTACHMENT	
10. SUBJECT OF AMENDMENT: This amendment eliminates the aggregate limit on supplemental inpatient payments to non-state government owned or operated rural public hospitals. It will result in additional reimbursement to certain rural public hospitals which will help maintain access to medically necessary services in rural counties.			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt. <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Jason Cooke State Medicaid/CHIP Director Post Office Box 13247 Austin, Texas 78711	
13. TYPED NAME: Jason Cooke			
14. TITLE: State Medicaid/CHIP Director			
15. DATE SUBMITTED: December 23, 2003			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: DEC 23 2003		18. DATE APPROVED: JUL - 6 2004	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT 11 2003		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Charlene Brown		22. TITLE: Deputy Director CMSO	
23. REMARKS:			

(v) Non-State Owned Rural Public Hospital Supplemental Inpatient Payments. Notwithstanding other provisions of this attachment, supplemental payments will be made each state fiscal year in accordance with this subsection to eligible rural public hospitals for inpatient services provided to Medicaid patients.

(1) For purposes of this subsection, rural public hospital means a public hospital affiliated with a city, county, hospital authority, or hospital district located in a county of less than 100,000 population based on the most recent federal decennial census.

(2) The supplemental payments described in this subsection will be made in accordance with the applicable regulations regarding the Medicaid upper limit provisions codified at 42 C.F.R. §447.272. The following method is used to reasonably estimate the Medicaid upper limit. Medicare payments subject to case mix adjustment are divided by a hospital's Medicare case mix index (CMI) to determine total Medicare payments for case mix of 1.0. Medicare pass-through payments are added, and the total is divided by Medicare discharges in order to determine a Medicare CMI adjusted payment per discharge. Medicaid payments subject to case mix adjustment are divided by a hospital's Medicaid CMI to determine total Medicaid payments for a case mix of 1.0. Medicaid pass-through payments are added, and the total is divided by Medicaid discharges in order to determine a Medicaid CMI adjusted payment per discharge. The Medicaid CMI adjusted payment per discharge is subtracted from Medicare CMI adjusted payment per discharge. The result is multiplied by the hospital's base year Medicaid CMI to determine a CMI adjusted Medicaid Medicare payment per discharge differential. This payment per discharge differential is multiplied by Medicaid base year discharges and inflated to the current period. The calculation uses base year paid Medicaid claims and cost reports. All managed care patients excluded from the calculation.

(3) The amount of supplemental payments and fee-for-service Medicaid inpatient payments (including DRG and TEFRA inpatient cost settlements) the hospital receives in a state fiscal year may not exceed Medicaid inpatient billed charges for inpatient services provided by the hospital to fee-for-service Medicaid recipients in accordance with 42 CFR §447.271.

(4) Supplemental payments will be made to two groups of rural public hospitals.

- (A) Rural public hospitals that have a deficit between fee-for-service Medicaid billed charges and fee-for-service Medicaid payments (including supplemental payments) greater than 1 percent of the total deficit between fee-for-service Medicaid billed charges and fee-for-service Medicaid payments (including supplemental payments) for all rural public hospitals. Medicaid billed charges and payments will be based on a twelve consecutive-month period of fee-for-service claims data selected by HHSC.
- (B) All other rural public hospitals that have a deficit between fee-for-service Medicaid billed charges and fee-for-service Medicaid payments (including supplemental payments). Medicaid billed charges and payments will be based on a twelve consecutive-month period of fee-for-service claims data selected by HHSC.

JUL - 6 2004

State: Texas
Received: 12/23/03
Transmittal Number: 03-024

Approved:
Effective: 10/11/03
Supersedes: 03-015